

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/19/2011
NAME OF PROVIDER OR SUPPLIER LAKEBRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 WOODLAWN DRIVE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During a complaint investigation at Lakebridge Health Care Center on October 19, 2011, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes. C/O: #28676	N 000			

Division of Health Care Facilities

Myda Bump
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

10/27/2011

STATE FORM

6899

ZTHR11

OCT 31 2011 If continuation sheet 1 of 1